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ABSTRACT

This guidebook was developed for early childhood administrators and consultants who provide services to support the integration of children with disabilities into preschool classrooms. It provides practical information on finding and hiring the best consultants, unraveling the special education and third-party payor resources that support specialist services, developing strategies that will ensure mutual understanding and respect, and instituting procedures that promote staff-consultant teamwork. Chapter 1 discusses the types of consultants who are available, their qualifications, and how to find them. Chapter 2 addresses funding options for consultant services, summarizing key legislation and describing programs that provide funding such as Medicaid, Head Start, and private insurance. Chapter 3 provides information on important elements to consider when designing a contract for a consultant or an outside agency and includes sample contracts. Chapter 4 examines the responsibility of the administrator and the consultant in supporting and understanding each other in order to forge a positive and productive working relationship. Appendices list Resource Access Projects and University Affiliated Programs. (Each chapter contains references.) (JDD)

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MAKING THE MOST OF CONSULTANTS

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and
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TABLE OF CONTENTS

PREFACE

INTRODUCTION 1
- Assumptions 1
- Organization of the Guidebook 2

CHAPTER ONE: CONSULTANTS 3
- What Services Do Consultants Provide? 3
- What Types of Consultants Are Available? 6
- How Can I Find the Consultants I Need? 8
- How Do I Choose the Best Consultant For My Program? 10
- Consultant Worksheet 12
- End Notes 13

CHAPTER TWO: THE FUNDING MAZE 15
- Federal Legislation—Rights and Protection 15
- Programs That May Provide Resources 18
- Summary 29
- End Notes 31
- Bibliography 32

CHAPTER THREE: CONTRACTS 33
- Understanding and Negotiating Fees 33
- Fee Structure Chart 35
- The Written Contract 37
- Sample Contract Between Preschool Program and an Agency 41
- Sample Contract Between Preschool Program and an Individual Provider 43
- End Notes 44
- Bibliography 44

CHAPTER FOUR: CREATING A PARTNERSHIP 45
- Responsibility for the Partnership 45
- The Specialist 46
- The Administrator 47
- When Difficulties Arise 49

CHAPTER FOUR, continued

Vignettes 50
Summary 54
Teacher/Consultant Checklist 55

APPENDICES

Appendix A—Resource Access Projects
Appendix B—University Affiliated Programs

PREFACE

In 1989, Boston Children's Hospital and Education Development Center, Inc. (EDC), received a grant to work collaboratively with North Shore Community Action Program Head Start in Beverly, Massachusetts. The purpose of the project was to incorporate the expertise of specialists at the University Affiliated Program (UAP) at Boston Children's Hospital into the Head Start program to increase services to children with more serious disabilities.

Throughout the two years, UAP staff, including a child psychologist, early childhood special educator, and physical therapist, provided weekly consultation and in-class support to teachers who were responsible for mainstreaming specific children.

EDC's role in the project was to document the process and, drawing on the project's experience, develop a guidebook for early childhood administrators and consultants who provide services to preschool children with disabilities in community-based programs.

The two-year process provided EDC staff with ample opportunity to interview key people in the preschool setting and observe numerous situations in which administrators, teachers, and consultants worked together both in and out of the classroom setting, with the goal of successfully integrating children with disabilities. Needless to say, we all learned a great deal about what works and what does not work when outside consultants provide services to children in preschool programs.

The resulting manual, ***Making the Most of Consultants***, represents the work and ideas of many people, most notably the administrators, teachers, staff, and consultants from North Shore Community Action Program Head Start in Beverly, Massachusetts.

Together with Marie M. Cullinane, M.S.; Bruce Cushna, Ph.D.; Jean M. Zadig, Ph.D.; and Elizabeth Zausmer, M.Ed., from Boston's Children's Hospital, as well as Mary Antes, Joanne Brady, Judy Brophy, and Peggy Enright from EDC, the North

Shore Head Start staff participated in a collaborative venture that was challenging, yet educational and productive for all involved.

The team from Children's Hospital and EDC would like to thank the many people who made this effort successful. We acknowledge our project officer from the Head Start Bureau, Jane DeWeerd, for her support and encouragement. We also extend special thanks to Sandra Waddell, director of North Shore Community Action Program Head Start, who, along with her very capable staff, demonstrated a commitment to integrating children with disabilities and was helpful and flexible throughout the duration of the project.

Finally, many of our colleagues at EDC provided technical support and expertise that greatly enhanced the final product. Anne McAuliffe's production assistance, Carol White's editing, Heidi LaFleche's proofreading, Peggy Goetz's production of the final manuscript, and Jim Hood's cover and manuscript design were of enormous help during the production process. Joanne Brady's leadership throughout the project and Maureen DeJong's and Margie Saéz's management during the production phase deserve special thanks. All of our colleagues at EDC contributed with their good humor and patience as well.

Making the Most of Consultants represents the results of a collaborative process and the lessons we have learned. Although most of the information in this guidebook is targeted to early childhood program administrators, we've included information and strategies that will benefit consultants as well. We hope that this guidebook will be an informative and practical tool that will enable administrators, staff, and consultants to better know, understand, and work with each other, in order to maximize the integration of children with disabilities.

INTRODUCTION

This guidebook is intended to help both administrators and consultants develop more effective partnerships that support the integration of children with disabilities into preschool classrooms. Specifically, it is designed to provide practical information on finding and hiring the best consultants for your program, unraveling the special education and third-party payor resources that support specialist services, developing strategies that will ensure mutual understanding and respect, and instituting procedures that promote staff–consultant teamwork.

Assumptions

As we developed the guidebook, the following assumptions guided our thinking:

- The goal of mainstreaming is to fully include children with disabilities into all activities in the classroom.
- Mainstream opportunities for young children with disabilities can foster their development by exposing them to a greater variety of materials, experiences, adults, and children.
- Integrated settings can provide all children with the chance to learn about, accept, and value human differences.
- Early childhood staff need both training and ongoing support to effectively mainstream children with a range of disabilities.
- Program administrators and other supervisors are instrumental in determining the success of any special effort such as mainstreaming. Their commitment is reflected in the policies and procedures they establish as well as the personnel and other resources that they devote to such an undertaking
- Therapists and other specialists can provide critical direct and supportive services to early childhood programs. Their effectiveness hinges on their ability to understand and respect the demands of the early childhood classroom

environment and to link interventions with the daily classroom routine.

- Administrators and staff of preschool programs can enhance the effectiveness of the consultant if they understand the consultant's role and are knowledgeable about the constraints he or she faces.

Organization of the Guidebook

This guidebook includes four chapters. Chapter 1 discusses the types of consultants who are available, their qualifications, and how to find them. Chapter 2 addresses some options for funding the services of consultants. Chapter 3 provides information on important elements to consider when designing a contract for a consultant or an outside agency and includes sample contracts. Chapter 4 presents the lessons we learned regarding the creation of a successful partnership, including issues related to the responsibility of the administrator and the consultant to support and understand each other in order to forge a positive and productive working relationship.

Chapter One:
CONSULTANTS

Head Start and other early childhood programs are providing mainstream services to young children with disabilities, with thousands of preschoolers with disabilities currently integrated into existing community programs in the United States. As children with more serious and complex problems are integrated into these preschool classrooms, directors, supervisors, and other staff need to enlist the services of outside specialists who can provide a range of direct services, support, and training.

Successfully integrating children with disabilities into preschool programs such as Head Start, day care, and state-funded programs is a cooperative venture. It requires all adults—administrators, teachers, consultants, and parents—to combine their skills to create a nurturing and productive learning environment, one in which the child feels fully included in all aspects of the program. Finding a consultant who has the qualifications and skills needed and is also aligned with the philosophy of the preschool can be made easier if the administrator knows ahead of time how to find, interview, and contract with consultants.

What Services Do Consultants Provide?

Specialists are available to provide a wide range of services to you and your entire program staff, or to individuals such as a teacher, parent, and child. Some of the services consultants provide to preschool programs are outlined below.

Direct Services to Children with Disabilities

Most frequently, consultants are used in the preschool setting to provide direct services to children with disabilities. In this capacity, specialists either assess children who are suspected of having a disability or deliver specialized services such as physical therapy to children who have already been diagnosed.

Assessment

Often specialists are called upon to observe a child and then recommend if the child needs further evaluation in order to determine if he or she has a disability. For example, as an administrator, you might hire a psychologist who has experience with preschoolers similar to those in your program (in cultural background, socioeconomic status, etc.) to observe and assess a child whose behavior is very disorganized and of

concern to the classroom teacher. Such an assessment will help you determine if a full evaluation is needed or if some other intervention is more appropriate.

Intervention

Once a child has been diagnosed as having a disability, a consultant is hired to deliver the services needed, which are usually specified in the child's Individual Education Plan (IEP).[1] This type of service involves a "hands-on" interaction between the therapist and the child to develop or improve particular skills. Usually, IEPs indicate which specialists are required to address specific goals established in the plan.

Best practice in direct service of this kind has changed a great deal over the past several years. Not long ago, most consultants hired in the above situation would take the child from the preschool classroom to a quiet room and provide therapy.

Increasingly, early childhood educators have realized the value of having the consultant join in the classroom and provide such intervention services within the context of the classroom. For example, the consultant might join in the ongoing activities of the classroom and then work with a small group of children (including the child with disabilities) in a structured activity such as singing a song or playing a lotto game where children's vocabulary is expanded. With this type of in-class intervention, the child with a disability receives the needed intervention but is not identified publicly as the recipient. Moreover, the group experience offers a context in which a child with a disability can interact with peers as an equal member of the group.

Although this type of direct service is not recommended for all children or in all situations, most experts agree that in-class interventions, where the consultant's work is integrated into small-group, ongoing activities, best serves the child with disabilities. It provides other advantages as well. For example, it helps the consultant see the whole child within the context of his or her daily environment, and the intervention provides teachers with a model of practical ways to actually carry over the intervention to the daily classroom routine.

Training and Consultation to Staff

Consultants are extremely valuable as trainers and technical assistance providers to staff, who usually need information, skill building, and support as they integrate children more fully into their classrooms. In some programs, specialists provide preservice or inservice training to staff on issues related to specific children with disabilities or on issues related to mainstreaming children in general.

Perhaps the most important role for the specialist in providing consultation to staff is in helping the individual teacher understand the therapist's intervention with a particular child and then assisting the teacher in developing ways to extend and build on it throughout the day.

In some situations, the consultant is not the provider of direct services to the child, but rather becomes a coach to the teacher, who is trained and supported to deliver the direct service within the classroom setting. For example, consultants are frequently used to assist teachers in adapting curricula or materials for a child with disabilities and then provide support for and monitoring of how the intervention is working. This model of consultant services is designed to increase the skill and understanding of the teacher and to help the child receive the services tailored to his or her needs while being fully included in the classroom.

Services to Parents

Parents of children with disabilities play a lifelong and critical role in determining the educational program for their children, and as such, need to understand fully the child's disability, be aware of direct services being provided to the child within the classroom, and realize their own value as a member of the child's team. Consultants are often called upon to help parents with these issues and to teach them strategies for supplementing therapy at home so there is consistency across all settings for the child. Consultants also help parents gain access to appropriate support groups, disability associations, and advocacy organizations.

Technical Assistance to Administrators

Administrators are key to creating the context for successfully integrating children with disabilities. As leaders, you establish priorities, define procedures, structure staff development activities, and allocate resources that support a child's and family's access to the total program.

Consultants can assist administrators with many of the above activities as well as an array of others. These include conducting an accessibility audit for programwide compliance with the Americans with Disabilities Act (ADA), which is described in Chapter 2; developing more efficient and effective screening and referral procedures; or strategizing techniques for recruiting children with disabilities.

It is unlikely that one specialist can provide all these services. The continuum of consultant services ranges from the specialist who only evaluates and makes recommendations for services to the specialist who only provides direct therapeutic services to children. In between there can be a bewildering assortment of resources and specialists, including consultants in multiservice agencies and consultants in private practice. In some geographic areas, however, you may have few options from which to choose. It is still important to be familiar with the types of consultants who are available and the standards they should meet in order to provide services to you, your staff, and the children and families you serve.

What Types of Consultants Are Available?

A wide variety of specialists are qualified to provide assessments and direct services to children with disabilities, as well as consultation, training, and technical assistance to you, the families you serve, and your staff. The types of consultants most frequently used in early childhood programs are occupational therapists; physical therapists; mental health professionals, such as psychologists, psychiatric social workers, and play therapists; and speech and language pathologists.

In most states these specialists are licensed or registered with a state agency, indicating that they have received the required level of professional training.

Occupational Therapists

Occupational therapists provide services that promote improved quality of movement and posture, fine motor functioning, visual motor functioning, and independence in daily living activities. They recommend, construct, and teach others to use and maintain adaptive equipment for such activities as positioning, feeding, writing, and the use of educational equipment and materials. For example, an

occupational therapist might assist a child who is not able to use a spoon or fork appropriately or help one who is unable to put pegs into a pegboard.

Physical Therapists

Physical therapists and licensed physical therapy assistants (LPTAs) provide services that promote improved quality of movement and posture, gross motor balance, strength and coordination, functional posture, appropriate positioning, and mobility. They recommend, construct, and teach others to use and maintain adaptive equipment such as wheelchairs, prone boards, and other devices. Physical therapists can provide services to children with a range of different conditions. For example, they frequently work with children with Down syndrome to improve muscle tone and with children with cerebral palsy to improve flexibility.

In most states, physical therapists work from a physician's prescriptions and are registered or licensed by a state board.

Mental Health Professionals

Psychologists, psychiatrists, and other mental health professionals, such as psychiatric social workers, psychotherapists, mental health specialists, and play therapists, offer an array of services to programs, including diagnostic testing of cognitive and psychosocial development, consultation on supporting specific children to strengthen social competence, and small group, family, and individual psychotherapy. In order to collect third-party payment, most states require that these specialists be licensed by a state board or work directly under the auspices of a licensed provider.

Speech and Language Pathologists

Speech and language pathologists conduct screenings, diagnoses, and treatment of children with communication disorders. They assess the child's ability to understand expressive and receptive language and produce speech. They may design and carry out a therapy program or recommend and teach others to use specific techniques to enhance and expand a child's communication skills. Speech pathologists are sometimes called speech clinicians or speech therapists. Most states require that these specialists obtain a Certificate of Clinical Competency (CCC).

These are but a few of the many specialists who are available to provide direct service, training, and consultation to preschool

programs. Other specialists who work with children with special needs, their parents, and program staff include early childhood special educators, nurses, audiologists, and nutritionists.

How Can I Find the Consultants I Need?

Depending on the location of your program, you may have many or few consultants from whom to choose. Still, it is important to know the pool of potential consultants, so you are able to best match your specific needs with the skills and expertise available.

For children who have Individual Education Plans (IEPs) developed prior to enrollment in your program, a consultant may already be identified and/or working with the child.

If a child comes to your program without an IEP, you will need to locate a specialist yourself once the child's needs are identified. The following list suggests possible places in your community to look for consultants:

Public Schools / Local Education Agencies (LEAs)

Public Law (P.L.) 94-142 is the Education of the Handicapped Act of 1975 that created a "right to education" for children with disabilities from school age to 21; its amendment, P.L. 99-457, later mandated services to the preschool population (ages 3 to 5) as well. This landmark legislation established the need for public schools to routinely use the services of consultants.

These two laws, recently reauthorized first as the Individuals with Disabilities Education Act (IDEA) or P.L. 101-476, and then amended to P.L. 102-119, now stipulate that education agencies receiving federal funds, as of the 1991 school year, must serve all children with disabilities between the ages of 3 and 21, thus making public schools a primary source for consultants and specialists who work with young children. Preschool program administrators can call the office of the administrator of special education in the LEA in order to gain access to the services of these providers.

Private Providers

Some consultants are individuals in private practice who do not provide services within the public schools. You may be able to find such consultants by networking with other providers or seeking recommendations from other preschool programs.

Community Agencies or Advocacy Groups

Many agencies, both public and private, may be able to provide services to your program. Examples include multiservice centers, community health clinics, local chapters of the March of Dimes or the United Cerebral Palsy Association, and the local Easter Seal Society. Some of these agencies have staff available for consultation, while others may be able to suggest specialists in your area.

Hospital Outpatient Clinics

Many hospitals offer a wide variety of services, both within the hospital and onsite. Some children who have been identified prior to entering your program may be receiving services from hospital staff on an ongoing basis or are being followed by therapists at a hospital clinic.

Resource Access Projects (RAPs)

The Resource Access Projects (RAPs) are a national support network designed to assist Head Start programs as they integrate children with disabilities into their programs. There are 12 RAPs across the country, each responsible for serving Head Start programs within one of the 10 existing federal regions or one of the migrant and/or American Indian programs. The RAPs provide training, technical assistance, and information to Head Start staff and link local programs with other agencies and organizations. Head Start programs can call upon their RAP to help them identify people and agencies that provide services to children with disabilities. A list of the current RAPs is included in Appendix A.

University Affiliated Programs (UAPs)

University Affiliated Programs (UAPs), located in almost every state, offer preservice and continuing education programs for many professional disciplines. The training usually stresses collaborative team efforts to address the comprehensive needs of children with serious disabilities. Generally supported by grants and fees, the UAPs can offer technical assistance as well as direct staff training and program development consultation. Their staff composition represents a spectrum of consultants skilled at promoting team planning and support for involved children. Some of the children currently enrolled in your program may already receive UAP services. A list of the current UAPs is included in Appendix B.

How Do I Choose the Best Consultant for My Program?

When hiring a consultant, you will want to make sure that the person meets at least the minimal requirements of professional education, training, and licensure needed to provide the service you are requesting. In addition, it is usually best to hire someone who has knowledge about and experience with three- and four-year-olds and understands the families you are serving, making it more likely that the specialist will set appropriate goals, have reasonable expectations for the child, and be able to make appropriate recommendations to the classroom staff and family.

In addition to these standards, you will want to hire someone who makes for a "good fit" with your program, who knows and accepts your philosophy and expectations, or who is interested and willing to discuss them. Sometimes a specialist can have all the necessary training and experience, but because of other more subtle dynamics, will not make for a good fit.

In general, you will want a consultant who can develop good rapport with children and adults, work cooperatively and communicate clearly with your staff and parents, and work within the context of your classroom philosophy and environment. By generating criteria that are important to you and your staff and then assessing the consultant on these dimensions, you will ensure a more successful relationship, and as a result, better services to the child within the classroom.

When choosing to bring a consultant into your program, some important questions to consider include

- Is the consultant interested in knowing your program's philosophy and is he/she aligned with your philosophy?
- Does the consultant agree with your ideas about his or her role in the preschool setting? For example, does he or she agree that the child's specific needs are not to be focused on to the exclusion of the child's self-esteem and socialization?
- Does the consultant show appreciation and respect for you and your staff members' expertise and skills?
- Does the consultant solicit your input and feedback? Does he or she see you, your staff, and the consultants as members of the same team?

- Does the consultant have an awareness of the demands on the teacher and the constraints the teacher faces? For example, does the specialist realize that he or she is a small part of the many things going on in the classroom for which the teacher is responsible?

- Is the consultant knowledgeable in his or her area of expertise, yet able to share information in a way that is practical and comfortable for staff?

- Is the consultant able to connect interpersonally with staff, parents, and children?

Some consultants will mesh with your program quickly and easily. Others will not. By thoroughly orienting a potential consultant so that he or she is clear about your expectations and priorities and by soliciting and working with the priorities of the specialist, you will maximize the chances of a good fit. A sample worksheet that can help you evaluate potential consultants appears on the following page.

CONSULTANT WORKSHEET

Name: _____

Type of specialist: _____

Type of services available:	YES	NO
Assessment of children	❑	❑
Intervention with children	❑	❑
Training for staff	❑	❑
Consultation to staff	❑	❑
Services to parents (specify)	❑	❑
Technical assistance to administrators	❑	❑

Rating of consultation on criteria established as important by staff:	YES	NO
Ability to communicate well with staff and parents	❑	❑
Understanding of the population served	❑	❑
Alignment with program philosophy	❑	❑
Sensitivity to demands on classroom teacher	❑	❑
Flexibility with regard to scheduling changes	❑	❑
Recognition that staff and parents are part of the team	❑	❑

Other early childhood programs (for which this consultant has worked) to call for recommendations:

1. Name: _____
   Phone number: _____
   Service provided: _____

2. Name: _____
   Phone number: _____
   Service provided: _____

3. Name: _____
   Phone number: _____
   Service provided: _____

END NOTES

[1] The Individual Education Plan (IEP) was mandated by P.L. 94-142. It establishes the need for an individualized written plan for each child receiving special education services that includes present level of educational performance, goals and short-term objectives, educational plan (including participation in regular educational program), beginning and ending dates for program, and schedule for periodic review.

Chapter Two:
THE FUNDING MAZE

Finding resources to pay for services for children with disabilities is probably one of the biggest challenges directors of preschool programs face. It requires an understanding of federal and state legislation that guarantees access to education and facilities for persons with disabilities. And it requires knowledge of the basic features of federal and state programs and private insurance policies that pay for services. Patching together a blanket of coverage for children who need services requires knowledge, perseverance, patience, and ingenuity.

This chapter covers two areas. First is a section summarizing key legislation that delineates the rights and protections of persons with disabilities. Following this is a description of programs that provide resources for services.

Federal Legislation—Rights and Protection

For nearly two decades, the federal government has been passing laws aimed at ensuring the rights of persons with disabilities. These laws prohibit discrimination based on physical or mental disabilities, require public buildings to be accessible to all people, and mandate free and appropriate education. The most recent legislation extends these civil rights to private-sector employment, public accommodations, services, and communication. This body of legislation can be divided into two groups: one group of laws addresses the right to a *free education* for children with disabilities, while the other group describes the rights of *access* to buildings, services, and programs for all persons with disabilities.

Below are highlights of these important laws—laws that administrators need to know and understand in order to provide the most appropriate services for the children in their programs.

Laws Related to the Education of People with Disabilities

Public Law 94-142, passed in 1975, mandated a "free and appropriate public education" for children with disabilities. This landmark legislation, known then as the Education of the Handicapped Act, had dramatic effects on the education system. Among other things, it established the need for Individualized Education Plans (IEPs) for children with disabilities and support services in the least restrictive

Section 504 was refined in 1990 with the passage of the Americans with Disabilities Act (ADA), P.L. 101-336. ADA is comprehensive civil rights legislation that creates sweeping protection of rights for people with disabilities in the areas of employment, public accommodation, transportation, and telecommunications. In effect since January 1992, ADA provides basic civil rights to all individuals with disabilities, similar to those provided to individuals regardless of race, sex, national origin, age, and religion.

ADA gives civil rights protection to individuals with disabilities in private sector employment (Title I), all public services (Title II), public accommodations (Title III), and telecommunications (Title IV). It further states that all government facilities, services, and communications must be accessible consistent with the requirements of Section 504.

The public accommodations section (Title III) is of particular concern for administrators of early childhood programs. It stipulates that public accommodations may not discriminate on the basis of the disability. In other words, physical barriers must be removed or alternative methods of providing services must be offered whenever possible. Likewise, new constructions must be accessible and alterations must be completed in an accessible manner.

While churches and other places of worship are excluded from the public accommodations section (Title III) and other sections of the law, if businesses such as early childhood programs and Head Start programs use space in churches and are open to the public, the exclusion granted to churches no longer applies. For example, if a Head Start program is renting space for two classrooms in a church, the church then must comply with Title III and is no longer considered exempt.

Also, with certain specific exceptions, Title III prohibits the use of eligibility criteria that tend to exclude persons with disabilities. This brings into question policies that exclude children with disabilities who are not toilet-trained as a result of their disabilities or who may have been excluded for other reasons.

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All of these laws affect early childhood programs and operations. It is imperative that program administrators become knowledgeable about the laws and know where to find additional information and technical assistance. RAP staff in your region (see Appendix A) are able to provide you with information, materials, and technical assistance as you sort through the legislation and learn its impact on your program and the children you serve.

Programs That May Provide Resources

A number of funding streams can pay for services for children with disabilities. Each program has its own eligibility requirements, list of approved services, and restrictions. To complicate matters further, most funding for these programs is funneled through the states, and each state establishes its own guidelines. The result is wide variation of requirements among programs and across states. This can be perplexing to even the most sophisticated preschool managers who have little day-to-day experience with these requirements. Moreover, a large number of Americans neither meet the eligibility criteria for government programs nor have insurance of their own. Still others are underinsured or have coverage that is not broad enough to include the range of services needed.

Consequently, services to children and families often rely on the knowledge and advocacy skills of administrators to gain access to existing funding, to ensure that children with disabilities receive needed intervention services from specialists described earlier. Below is a description of a number of programs, identifying the key characteristics that might help you find those that have most applicability to children and families in your program.

The Medicaid Program

Title XIX of the Social Security Act, passed in 1965, is a source of health care funds for a large number of children with disabilities. Called Medicaid, Title XIX is essentially a health care program for eligible low-income people of all ages. Services vary from state to state because Medicaid is financed jointly by the federal and state governments. At the federal level, the program is administered by the Health Care Financing Administration, an agency of the U.S. Department of Health and Human Services. At the state level, it most

commonly operates through the department of welfare, public health, or social services, or through a state Medicaid office. (Title XVIII of the Social Security Act of 1965 is the Medicare Program, a nationwide hospital [Part A] and supplementary medical [Part B] insurance program that serves people age 65 and over and some younger people who are disabled or suffer from permanent kidney failure.)[1]

The federal government has established broad guidelines to regulate the Medicaid program. These include the groups of people who must receive services (the "categorically needy"), a list of core services that must be included in any state program,[2] and optional services that a state may elect to provide.[3] Each state develops its own plan, which must be federally approved. It delineates who is eligible for services; the type, amount, duration, and scope of services; and the rate of reimbursement for services. It is important for educational agencies to work with their state Medicaid agency to ensure that the categories defined in the state plan are those that are most needed by the children they serve.

The Medicaid statute and the regulations that govern the program are among the most complex of the entire federal bureaucracy. The information that follows is a general outline of the program; for specific details contact the Medicaid office in your state.

The basic provisions of Medicaid are as follows:

- Medicaid is an entitlement program. *All* people who meet the eligibility requirements are entitled to and must be provided with services, regardless of the cost. Specifically, all children under age 6 with family incomes below 133 percent of the federal poverty level and all children eligible for Supplemental Security Income (SSI) and Aid to Families with Dependent Children (AFDC) are eligible for Medicaid. By the year 2002, states will be required to provide Medicaid coverage for all school-aged children up to age 19 in families with incomes below 100 percent of the poverty level. States must redetermine Medicaid eligibility at least every 12 months. Medicaid recipients usually do not pay any portion of the cost of care.

- The federal government's share of the cost of Medicaid is determined annually by a formula that compares the state's average per capita income level with the national average. By law the federal share cannot be lower than 50 percent or more than 83 percent (Waid 1991).

- To be reimbursed by Medicaid, services must be based on a physician's authorization and provided by someone who has been recognized by the state as a Medicaid provider.

- Medicaid is the "payor of last resort." This means that the state must try to collect reimbursement from all public and private sources first. Only then can Medicaid be requested to pay. Furthermore, Medicaid cannot be billed if the same services are offered free to people in similar circumstances.

- Payments for Medicaid services are made directly to the person or vendor providing the service. To participate in the program, service providers must be recognized as a provider in the state plan and agree to accept the Medicaid reimbursement level as payment in full.

In times of prosperity, states often expand Medicaid services. When resources are limited and states want to control Medicaid costs, they attempt to limit the eligibility criteria and the available services outlined in the state plan.

To receive Medicaid services, applicants complete a form provided by the state through the local welfare or Social Security office. They must provide proof of their income level, citizenship, personal circumstances (i.e., proof of age, unemployment), and disability. The state must make a decision about the applicant's eligibility within 45 days, or 90 days if the applicant is disabled (Lewin/ICF and Fox Health Policy Consultants 1991).

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The EPSDT program is of particular interest to early childhood education administrators. Enacted in 1967 as a mandatory service under Medicaid, EPSDT is intended to provide all Medicaid-eligible children from birth to age 21 with a comprehensive and periodic evaluation of their health, developmental, and nutritional status. Evaluations include

vision and hearing screenings, dental care, and diagnostic and medical treatment for conditions discovered during the screening process. EPSDT coverage includes physician services, outpatient hospital services, case management, eyeglasses, physical therapy, prescription drugs, prosthetic devices, rehabilitation, speech-language-hearing therapy, chiropractic services, wheel chairs, and private duty nursing.[4]

The Omnibus Budget Reconciliation Act (OBRA) of 1989 strengthened EPSDT by

- extending eligibility to include all children up to age 6 in families with incomes up to 133 percent of the poverty line
- expanding the pool of eligible providers to include those who provide some but not *all* EPSDT benefits
- allowing more checkups when an illness or condition is suspected regardless of periodicity schedule
- mandating vision, hearing, and dental screenings and services at intervals that meet reasonable standards of medical and dental practice (e.g., dental screens now begin no later than age 3)
- requiring states to provide follow-up or treatment for disabilities, illnesses, or conditions discovered during a screening examination or that have increased in severity, even when those services are not included in the state's Medicaid plan

In 1990 OBRA then phased in coverage for all children in families whose incomes fall below the poverty line and who are born after September 1993. These children will be covered by Medicaid until they reach the age of 18.

In practical terms, for all eligible children, states are required to

- provide a complete comprehensive health examination, including a health and developmental history, an unclothed physical examination, hearing and vision testing, and appropriate lab tests and immunizations

- provide dental care that includes a dental examination starting at age 3 and care as needed
- treat conditions discovered during the screening process

Head Start Programs

The Administration for Children and Families, which is Head Start's funding agency, is committed to providing "all needed services" to children with disabilities enrolled in the program. IDEA further strengthens the mandate for program accessibility. The need for services to individual children is determined through the IEP process. Community resources are to be used to meet those needs. By actively recruiting children with disabilities, Head Start administrators can plan appropriately to ensure that their annual budget request reflects the needs of their forthcoming enrollment. In addition, supplemental budget requests can be submitted for unanticipated enrollments. A child with serious disabilities cannot be denied access to a Head Start program if

- the child and the child's family meet Head Start eligibility requirements
- the child's parents want the child placed in the Head Start program
- the program has not already exceeded its funded enrollment

Social Security Administration Programs

Social Security is a government program that pays retirement benefits, disability benefits, and survivors' benefits. Eligibility is limited to those who have been employed long enough and recently enough to earn Social Security credits. Only children whose parents have been disabled may benefit under the basic Social Security program.

However benefits to individuals with disabilities are available under two Social Security programs based upon need: Supplemental Security Income (SSI) and Title V/Maternal and Child Health Block Grants. Medical requirements are the same for both programs, as is the manner in which a person's disability is determined.

Supplemental Security Income (SSI)

SSI is an income supplement program for persons of low income who are 65 or older, or people of any age who are disabled or blind. Aid currently ranges from $1 to $407 per month per individual. Those who receive SSI are automatically eligible for Medicaid, and about half the states supplement SSI payments.

New SSI regulations have updated definitions of specific disabilities and expanded the list of physical and mental conditions that establish SSI eligibility conditions.[5] Now included are psychoactive substance dependence disorders, Attention Deficit Disorder (ADD), Down syndrome, Fetal Alcohol Syndrome (FAS), phenylketonuria (PKU), and developmental and emotional disorders of newborns and younger infants. Under the new regulations, a child disability can be established in three ways:

- the presence of a specific condition on SSA's List of Impairments
- demonstration that the disability is medically or functionally equivalent to a listed condition
- completion of an individualized assessment to evaluate how the child functions, compared to other children the child's age, based on both medical and nonmedical evidence

"Other factors" that affect how a child functions, such as chronic illness, side effects of medication, or the need for structured or highly supportive settings and/or multi-disciplinary therapy, are also considered in determining SSI benefits.

If you have children in your program who you think may be eligible for SSI, or children who have previously been rejected, encourage the child's family to contact the local Social Security Administration or call their toll-free number at (800) 772-1213, or the Zebley Implementation Hotline at (800) 523-0000. You can also help the family gather medical and nonmedical information required to support the child's application.

Title V/Maternal and Child Health Block Grants

Since its passage in 1935, Title V of the Social Security Act has provided ongoing funding for child health services as part of health programs for mothers and children. Services are generally provided through state health agencies and physicians on a fee-for-services basis and are usually clinic-based.

Each state has a state-level maternal and child health (MCH) agency; MCH programs for children with special health care needs, however, may be located in a different part of the health department or in a separate agency altogether.

Individuals with Disabilities Education Act (IDEA), P.L. 101-476

Part B, Federal Pre-School Program (IDEA)

Part B was originally known as the Education for All Handicapped Children Act of 1975 (P.L. 94-142). As now amended, it requires states to ensure that all eligible children with disabilities, beginning at age 3, receive a free and appropriate public education. This is done through a multidisciplinary assessment followed by a written Individualized Family Service Plan (IFSP). By the 1992-1993 school year this special education mandate was in place in every state (Kahn and Heekin 1991). Currently five states—Iowa, Maryland, Michigan, Minnesota, and Nebraska—as well as American Samoa, Guam, Palau, and Puerto Rico mandate special education for eligible children from birth.

Part B is permanently authorized and provides funds to local education agencies to help pay the additional costs of educating students with disabilities. Such funding is based on the number of children receiving special education and related services.

Part B policy allows providers to bill Medicaid for health-related services. However, an "agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat" of financial loss to the parents, such as through a deductible clause, decrease in available lifetime coverage, or increases in premiums. Similarly, if Medicaid imposes cost sharing on Medicaid recipients for health-related

services in an IEP, the State or Local Education Agency is responsible for the copayment (Walsh 1992).

Part H, Program for Infants, Toddlers, and Families (IDEA)

Part H was originally enacted as Title I of P.L. 99-457, in recognition of the value of early intervention with children with developmental delays or at risk of delay. It is a discretionary program that focuses on the child within the context of the family and requires that the family actively participate in the child's assessment and treatment.

Federal funds help states develop and implement a statewide comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities and their families. The plan must include definitions, policies, timelines, interagency agreements, systems for identifying children, and procedures for collecting data, evaluating, and monitoring services. Once state plans are implemented, Part H services become an entitlement program, making all infants and toddlers with disabilities and their families eligible for early intervention services.

Most early intervention services are to be provided at no cost to parents. To pay for needed services, state agencies can gain access to Part H federal funds (used primarily for planning and expansion of services), other federal funds such as Medicaid and Chapter 1, private insurance coverage, and state appropriations.

Other Sources of Funding

Developmental Disabilities Basic State Grants

This is a relatively small grant program authorized by the Developmental Disabilities Assistance and Bill of Rights Act of 1990 to plan, coordinate, and deliver specialized services to help persons with developmental disabilities achieve their potential through increased independence, productivity, and integration into the community. States identify existing gaps in services and create a state plan that establishes priority service areas. Funds may be used to enhance coordination, conduct outreach activities, and train persons with developmental disabilities and their family members to gain access to services.

Children with Disabilities

This program, authorized by the Hawkins/Stafford School Improvement Act, provides special education classes in the local school system through educational support in state-operated and state-supported facilities. Under this program, states may acquire equipment and instructional materials, employ and train personnel, and identify and involve children with disabilities and their families in a broader range of services.

Hill-Burton Program

In 1946, Congress passed a law giving hospitals and other health facilities such as nursing homes, clinics, and rehabilitation centers money for construction and modernization. In return for these funds, the facilities agreed to

- provide a reasonable volume of services to persons unable to pay
- make their services available to all persons residing in the facility's area

Services are provided on a sliding scale for facility costs only; doctors' bills are not covered.

To obtain a list of Hill-Burton facilities, call the Department of Health and Human Services (HHS), which administers the program at their toll-free number (800) 638-0742. By reviewing the list of facilities and calling those in your area, you may locate a potential source of services available at no or reduced cost to the children in your program.

Private Insurance

An estimated 86 percent of full-time employees receive health care benefits through their jobs (Regan 1991). Approximately 70 percent of all children are covered by some type of private insurance, with the overwhelming majority of those (almost 90 percent) being covered by some type of employer-sponsored plan (White and Immel 1989). Health insurance can also be purchased as individual or group coverage.

Although benefits from private health insurance vary widely in form and coverage, there are two broad categories, described below.

Traditional Private Insurance

Traditional private insurance limits reimbursement to those services listed in the insurance policy, but health care services can usually be obtained from any licensed provider. Reimbursement is often subject to a number of provisions, such as

- *Pre-existing condition* exclusionary clause. A medical condition that was known at the time the policy was purchased may not be covered.

- *Deductible clause.* The company offers lower rates if the owner of the policy pays a portion of each bill. For example, if the policy has a $250 deductible clause, the owner pays the first $250 of the bills for services. Thus, for therapy costing $50 per session, the policy owner pays for the first five sessions but all succeeding sessions are reimbursable.

- *Copayment arrangement.* Depending on the policy, your program or a state department of public health could pay for all or a portion of the cost of those first five sessions, and the insurance company would pay for the remainder.

- *Lifetime benefit.* In this situation, a maximum amount of benefits can be paid over the duration of the policy; once that cap is reached there is no further coverage.

- *Limitation* on the number of certain types of services that will be covered.

The service provider submits bills to the insurance company for reimbursement. The difference between what the company will pay and the amount of the bill, if any, is sent to the family of the patient for payment.

Managed Care

The second category of private health insurance is called managed care. The most common types are described below.

- *Health maintenance organizations* (HMOs) consist of a group of health care providers who agree to provide enrollees with a designated range of health care services. Enrollees pay a fixed amount regardless of how many services they use. Services must be obtained from providers associated with the HMO or from their referrals.

- *Preferred provider organizations* (PPOs) are similar to HMOs except that enrollees are free to obtain covered services from any qualified health care worker; reimbursements are smaller if they go to someone who has not been designated as a preferred provider.

Many employers provide health insurance at no cost to their employees; others share the cost with their employees. However, employers are increasingly concerned about the rising costs of these benefits and are looking for ways to control or reduce the cost. Typically, this involves increasing the workers' share of the cost, which often leads to a reduction in family or dependent coverage.

When children in your program have private health insurance, you will want the name and address of the insurance company or other provider, the services covered, and the billing procedure so that your staff or the consultant can seek reimbursement for services rendered.

Children Without Insurance

Workers in low-paying or part-time jobs are often not eligible for employer-provided health benefits and often cannot afford to purchase insurance. According to an analysis of the March 1990 Current Population Survey, approximately 11.6 million of the 31 to 37 million uninsured are employed heads of families. Other uninsured workers total 7.2 million, nonworkers total 5.7 million, and children number 9.9 million. And these numbers are increasing (Regan 1991).

People with serious health problems often have enormous difficulties obtaining insurance if they don't already have it. Even when they have insurance, many people find that the

coverage is not adequate or that it will not pay for the services needed.

It is a real challenge to pay for consultants for children from families whose income is above the Medicaid eligibility guidelines and who have no health insurance or inadequate coverage. For many families in these circumstances, the alternatives range from foregoing needed care to spending down family income and assets to achieve eligibility for Medicaid or Programs for Children with Special Health Care Needs (formerly known as Crippled Children's Service) (Newacheck and McManus 1988).

One possibility is the use of "high-risk pools," an option now offered in more than 30 states. However, the premium cost to members of such groups can be as much as twice the cost of a standard private health insurance premium. Some states subsidize the rates for families unable to purchase insurance. Because these plans operate at a loss, a state may assess all health insurers within its borders. Other states allow tax breaks to the insurers in return. Insurance coverage obtained through risk pools is adequate, but the demand for such insurance often exceeds the supply.

Summary

Increasing recognition of the need for better and more accessible health care is leading to the introduction of health care legislation at both the state and federal levels. Because the federal government and most states are experiencing budget problems and because the cost of health care is rising at a rapid rate, we are not likely to see substantial relief in meeting the challenge of securing funding for services for children with disabilities. It is important to keep abreast of changes to existing legislation as well as to new legislation.

First, you need to be familiar with the range of funding sources available—particularly Medicaid, EPSDT, and IDEA—in your state and locality, their eligibility requirements, and how to gain access to them.

Second, you should actively solicit the contributions of individuals and organizations in your area to augment and, in some cases, provide services to children who fall outside the

eligibility criteria for mandated services. For example, service clubs such as the Lions Club and Kiwanis can sometimes be approached for funding, particularly for extraordinary expenses rather than ongoing services. Some groups may even hold annual fundraising events to pay for needed services for your program.

Finally, it is also important to voice your opinion and share your experience with those who shape policies, legislation, and regulations. Such actions can make a difference in the life and health of children.

ENDNOTES

[1] States must provide services to recipients of Aid to Families with Dependent Children (AFDC), the aged, blind, and persons with disabilities who receive Supplemental Security Income (SSI) funds, pregnant women, and children under age 6 whose family income does not exceed 133 percent of the federal poverty line, all children to age 19 who were born after September 30, 1983, and whose family income is at or below the federal poverty level, and special protected groups such as individuals who lose cash assistance but may keep Medicaid for a period of time.

[2] Required services include inpatient hospital, outpatient hospital, physician, laboratory and X ray, nursing facility services for individuals age 21 and over, home health care for persons eligible for nursing facility services, family planning services and supplies, rural health clinic, federally qualified health center services, nurse-midwife, certified pediatric or family nurse practitioners, prenatal care, early and periodic screening, diagnostic and treatment, and assurance of the availability of necessary transportation.

[3] States can choose from among more than 30 optional services such as dental services; case management services; physical, occupational, and speech therapy; rehabilitation; personal care; or other practitioners' services.

[4] EPSDT presently consumes only about 0.2 percent of the national Medicaid budget, serving 2,521,000 children in 1989 at a cost of $146,335,000. The National Public Health Service's Health Objectives for the Nation for the Year 2000 has set a goal to increase to at least 95 percent the proportion of EPSDT-eligible children who participate in the full complement of EPSDT services (White and Immel 1989).

[5] These new regulations are the result of a 1990 Supreme Court decision, *Sullivan v. Zebley*, which found that the disability regulations of the Social Security Administration discriminated against children by requiring them to meet a standard inappropriate for their age.

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Chapter Three: CONTRACTS

Once you have decided which consultant's expertise and philosophy best match your needs, and you have found the appropriate source of money to pay for consultant services, you need to develop a contract. Written contracts are important for a number of reasons. At the very least, they encourage administrators and consultants to think realistically and be explicit about mutual expectations, responsibilities, time frames, fees, and reporting mechanisms.

For most preschool programs, diminishing financial resources, coupled with increased demand for outside services, make the issue of negotiating and paying fees of utmost importance. Typical ways that fees are structured, followed by tips for developing a sound contract, appear below.

Understanding and Negotiating Fees

There are three basic ways consultants charge for their time: for the actual time spent providing the service, for the completion of a project regardless of actual time spent, and by retainer.

Fee for Service

You can employ consultants for a fixed period of time at a fixed rate to perform specific services for children in your programs. The service might be performed once or many times. For example, you might hire a consultant for two therapy sessions per week for the duration of the program year at $25 per hour, or you might hire a consultant for one two-hour workshop for staff and parents, for a fee of $150. In effect, you are buying the consultant's time. Most insurance companies reimburse specialists in this way, at a set hourly fee, for a certain number of sessions.

Payment for a Project

You can also employ consultants to complete a specific job. Once both parties agree on the fee, the job could take 20 or 30 hours without changing the fee, as long as the scope of work is within the terms of the contract. For example, you might contract with an agency to provide all your mental health services for the program year for a set fee. Over the course of the year, the consultant might see 10 or 15 children for the same fee. Such an arrangement presumes that both parties have a fairly accurate idea about how many hours will actually be spent providing the service; otherwise, one of you will be short-changed.

Payment by Retainer

You can also pay an agency or an individual a set fee for regular, ongoing work. For example, your program may have a lawyer or a consulting clinical psychologist on retainer. With this type of arrangement, you pay a set fee up front, with the agreement that the specialist will provide you with services, drawing from the allocated amount until it is depleted.

For example, you may give a psychologist a $1,500 retainer to provide you with consultation and technical assistance as needed. The psychologist keeps track of the time spent, drawing the negotiated hourly rate as the services are provided. When the initial retainer has been depleted, you can decide if additional consultation with this specialist is needed.

Such an arrangement is efficient and effective if you have a good sense in the beginning about how worthwhile the services are and how many hours of service you might actually need. A retainer also ensures that a specialist who knows you and your program will be available to you to provide everything from simple quick answers to intensive technical assistance. Finally, many specialists will negotiate for a lower hourly rate if they are kept on retainer.

The chart on the next page, adapted from *Selecting and Working with Consultants* (Ucko 1990), highlights a few of the advantages and disadvantages of each payment system.

FEE STRUCTURE CHART

FEE STRUCTURE	ADVANTAGES	DISADVANTAGES
Fee Based on Time		
Fee is based on the number of hours or days X the hourly or daily rate ($25 per hour X 10 hours = $250).	You pay only for the time actually worked.	You don't know in advance how much you will have to spend overall. There is no incentive for efficiency.
Project Fee		
You and the provider agree in advance on a fixed fee for the project, regardless of the amount of time it takes.	You know in advance how much the services will cost. You don't worry about the consultant spending extra time.	You may spend more than necessary if you over-estimate the time it will take. You will have to pay extra for services that are not specified in the contract.
Retainer		
You pay the consultant a set fee for recurring work and assurance of availability for additional work.	You are assured of the consultant's availability. You may get a reduced rate, or you might not be charged for brief calls.	You may use the consultant more than you need, since you are already paying for the services.

As an administrator you'll need to become an educated consumer in order to get the best services for your program, at the best rates. You should take into account several factors that influence billing rates:

- *The area of expertise.* Fees vary according to specialty. For example, psychiatric services will probably cost more than nutrition services. A bilingual speech and language pathologist will probably cost more than one who is not fluent in a second language.

- *The location of your program.* Consultants may cost more in metropolitan areas where the cost of living is higher. On the other hand, they may cost less in some areas because there is more competition.

- *The size of the agency with which you are contracting.* Small agencies and individual practitioners may cost less than large agencies.

- *The experience and reputation of the specialist or the agency.* A specialist who is well known or considered an "expert" is usually more costly. This may also be the case for agencies that are prestigious or in demand.

When negotiating with consultants or agencies, and in particular in the area of fees, it is of critical importance to write the terms of the agreement as clearly and precisely as possible. For example, make sure that any agreement on fees addresses the following:

- Will you reimburse the consultant for out-of-pocket expenses such as telephone, copying, or materials? Will you provide such services onsite?

- Will you reimburse for travel? If so, at what rate?

- Is an hourly rate based on a full 60-minute hour?

- Does the hourly rate cover time door to door, or only time spent actually delivering services?

- Is the rate the same if the specialist works with a small group of children rather than with one child at a time?

- Does the specialist charge extra for time spent talking with teachers and parents and writing reports?

Finally, you should not hesitate to discuss fees with consultants or negotiate for lower rates. Often specialists are willing to reduce their fees, particularly in a competitive market and if they are aligned with your philosophy. Figure out what you can afford to pay and let the provider know if cost is a big factor in your decision.

The Written Contract

When you have selected the consultant and reach consensus about the terms of payment, a contract should be developed describing the exact terms of your relationship. A contract is a binding agreement between two or more people or parties; generally it is written and spells out what the consultant will do in exchange for a fee and describes your responsibilities.

The Importance of Contracts

The importance of a clear, specific, and comprehensive contract cannot be overstated. It is the cornerstone of a successful partnership; if it is well crafted, it reflects communication and understanding between the two parties regarding roles and responsibilities. The contract also provides you with a tool to refer to when the partnership is not working well. It is a legal document for both parties, and as such, provides you with leverage should the partnership fail.

A written contract need not be lengthy or complex; it can be a letter that both parties sign or a multipage document. Whatever the size and style of the document, you would be wise to involve an attorney initially for input on what contracts should contain in general, and then again to review specific contracts before you sign them.

Items to Include in a Contract

All contracts should specify such details as the time period to be covered, fees, exact responsibilities of the specialist as well as the administrator or designee, and ongoing communication mechanisms or reporting procedures. Depending on the type of specialist or agency with which you are contracting, you might also want to consider other items particular to your situation. Below we list some of the topics covered in successful contracts.

- *Time period.* When will the service period begin and end? For example, you might develop a year-long contract for services that meshes with your school year. The language might read: "The contract period is from October 1, 1992, through September 30, 1993."

- *Scope of work.* What will the consultant do and what will the administrator do, and in what manner? The contract might specify: "The consultant will provide a two-hour, highly interactive workshop, and the administrator will provide a room with an appropriate setup and refreshments."

- *Key personnel.* Who will perform the work and who will supervise the work? As the administrator you may negotiate the terms of the contract and sign it, but the assistant director of your program might oversee the specialist's work on a day-today basis. The contract might specify: "The director will manage all financial aspects of this contract and the special needs coordinator will oversee the consultant's work."

- *Logistical arrangements.* When, where, and how will the work be performed? A sample contract might read: "The speech and language pathologist will provide direct services within Jennifer Howe's classroom once a week, on Tuesdays, from 10:00 to 10:45 A.M. The in-class intervention will include other children as well as the child needing special services."

- *Ongoing feedback.* What is the agreed-upon procedure for providing feedback? For example, the contract might stipulate: "The consultant will meet with the administrator or designee on the second Tuesday of every month, from 2:00 to 2:30 P.M., to review services, share information, and discuss next steps," or "The consultant will debrief with the classroom teacher for 10 minutes after every in-class session, at a mutually agreed-upon time, but not during class time."

- *Written reports.* When are written reports due? Many administrators feel that because of the lag time between diagnosing a child and obtaining services, it is useful to

include in the contract a statement such as: "Written reports will be submitted within 30 days of a diagnostic evaluation."

- *Schedule of payment.* What is the fee for the service, and what exactly does it cover? For example, does it include preparation time, travel, time for report writing, or direct services only? The contract should cover these specifics.

- *Assurance of confidentiality.* The contract should contain an agreement that the consultant will honor confidentiality.

- *Special clauses.* If the contract is with an agency and not an individual, you might want to include such provisions as the right to refuse any individual specialist (for example, one who is not aligned with your philosophy or who does not understand your population), or a stipulation that the administrators of the two programs meet or communicate regularly, perhaps monthly or twice yearly, to review progress and discuss any problems or issues that need to be resolved at the administrative level.

- *Termination or cancellation policy.* In the event that the partnership seems unworkable, it is in the best interest of all involved to have a termination policy as part of the contract. For example, a contract might stipulate: "This agreement may be terminated by either party upon 30 days written notice to the other party."

Contractual relationships work best when both parties believe the terms of the agreement are fair and when responsibilities are clear. Both parties will want to monitor the relationship, particularly if it is a new one. Is the consultant working with the child appropriately, making progress, communicating with classroom teachers, and spending the amount of time with the child and staff that is stated in the contract? Is the program providing working space and agreed-upon materials? Is it notifying the consultant when the child is absent? Is the teacher reinforcing the therapy when instructed to do so? It is important to communicate regularly to resolve difficulties before they develop into problems. Throughout the year, make note of problem areas so that when you negotiate new contracts, you can modify the terms and avoid the same pitfalls.

Two sample contracts, adapted from the North Shore Community Action Program Head Start in Beverly, Massachusetts, follow.

SAMPLE CONTRACT BETWEEN PRESCHOOL PROGRAM AND AN AGENCY

OCCUPATIONAL THERAPY SERVICE AGREEMENT

This agreement made and entered into this first day of October 1992 by and between the North Shore Community Action Program Inc., Head Start (the School) and Beverly Hospital (the Hospital).

The parties hereby agree as follows:

I. PURPOSE

The purpose of this agreement is to arrange for provision of direct occupational therapy screening, diagnostic, and therapy services to children referred by personnel of Head Start. Occupational therapy services will be provided by licensed staff of Beverly Hospital Occupational Therapy Department.

II. RESPONSIBILITIES

A. The Hospital Occupational Therapy Department shall:

1. Provide a licensed Occupational Therapist to the School for direct services to children subject to a mutually agreeable schedule.

2. Provide consultation services to the School to include:

   a. Consultation to School staff regarding occupational therapy evaluations and management, to include case findings and case review as appropriate.

3. Provide occupational therapy evaluations at the School for any student referred or identified as needing this service by the School or occupational therapist.

4. Provide direct occupational therapy services to students in individual and/or small-group settings as appropriate for achievement of goals.

5. Instruct School staff and parents in methods of assisting students that will build on the work of the therapist.

6. Maintain records and reports in accordance with current policies and procedures of the program. All records will be maintained in accordance with FERPA[1] regulations.

7. The occupational therapist will be subject to the policies of both the School and the Hospital.

B. The Head Start Program shall:

1. Provide work space conducive to the provision of services in the School setting.

2. Cooperate in arranging for scheduled appointments, consultation, and provision of services.

3. Make available case records as appropriate.

4. Notify the occupational therapist or the Hospital of School cancellations by telephone at least 2 hours prior to the time scheduled for therapy services.

5. Provide completed insurance forms and consent forms prior to the first session with the child so that the Hospital can bill the child's insurance and/or guarantor directly for the provided occupational therapy sessions.

C. Mutual

1. Provide periodic review of the occupational therapy service program, policies, and future considerations.

2. Notify the respective party when student or occupational therapist is unavailable for his/her scheduled appointment.

III. TERMS OF THE AGREEMENT

A. The Hospital will bill each student's insurance carrier individually for each session rendered.

B. This Agreement will be in effect for the period of October 1, 1991, to July 1, 1992. A review of this Agreement will be completed prior to June 1, 1992, by both parties for renewal considerations.

C. This Agreement may be terminated by either party hereto upon 30 days prior written notification to the other party hereto.

In witness whereof, the parties have caused this Agreement to be executed under seal by their respective officers hereunto duly authorized on the date above written.

BEVERLY HOSPITAL
(Signature and date)
(Occupational Therapy
Supervisor's signature and date)

HEAD START
(Signature and date)

SAMPLE CONTRACT BETWEEN PRESCHOOL PROGRAM AND AN INDIVIDUAL PROVIDER

MENTAL HEALTH SERVICE AGREEMENT

Provider:

Purchaser:

Contracted Period: October 1, 1991, through September 30, 1992

Scope of Work: Providing mental health consultation to Head Start

CLINICAL RESPONSIBILITIES

- Consult with Head Start staff on an every-other-week basis (1.5 hours)
- Maintain records and reports in accordance with current policies and procedures of the program. All records will be maintained in accordance with FERPA[2] regulations.
- Meet with Head Start administrator and coordinators to review services provided by specialist (at least biannually)
- Give Four training sessions (2 hours each)
- Provide *Better Safe Than Sorry* workshops for each classroom and the *Homeless Program*

RESPONSIBILITY OF PURCHASER

- Provide space for meetings

FINANCIAL ARRANGEMENT

The Head Start Program (the purchaser) agrees to pay_____ (name) up to $2,275 for 47.5 hours at the rate of $50 per hour. The total dollar value will be based upon the provision of services.

_____ (name) will generate a monthly bill based upon the time provided per calendar month of service.

Payment for services is expected within 30 days after receipt of invoice.

All correspondence concerning billing should be addressed to:

CANCELLATION

This contract is subject to cancellation by either party within 60 days notice in writing.

MANAGEMENT

All services contracted under this agreement will be under the direction of _____ (name) will manage all financial aspects of this contract.

SIGNATURES

(Provider's authorized signature and date)

(Purchaser's authorized signature and date)

ENDNOTES

[1] FERPA, referred to in the example above, is the Family Educational Rights and Privacy Act of 1974. It protects the privacy of students and parents and assures parents' access to their child's records. P.L. 94-142 also makes these assurances.

[2] Ibid.

BIBLIOGRAPHY

Ucko, T. (1990). Selecting and working with consultants: A guide for clients. Los Altos, CA: Crisp Publications, Inc.

Chapter Four:

CREATING A PARTNERSHIP

Successful working relationships hinge on many factors: doing your homework to assess your needs and desires, hiring a competent person who is a good match for your program, and developing a thorough contract, to name a few. But any experienced administrator will tell you that a successful partnership takes much more than this, and that signing the contract is usually just the first step.

The consultants or therapists who come into the classroom can feel to all involved (including the consultant) like either a member of the team or an intruder, depending on a number of factors. It is important to recognize that even though the administrator, parents, classroom teacher, and the consultant are all interested in providing the best program for the child (and have had many discussions regarding such), their training, experience, and goals for the child still may be different. Most early childhood administrators agree that consultation works best when a true partnership is formed, with the specialist a part of the preschool program team. Such a partnership is not a product, but rather an ongoing process whose first stages are successful negotiating, hiring, and contracting.

In this chapter we discuss some of the ways administrators and consultants can create and manage a successful partnership with consultants.

Responsibility for the Partnership

Although parents, teachers, and other staff members share responsibility for helping to create a partnership, it is the administrator and the consultant who must assume most of this responsibility. In fact, the partnership might be successful only if each assumes 100 percent responsibility for the relationship, rather than the unspoken 50 percent that many partners assume.

Below we outline some ideas and strategies for administrators and specialists to consider as they forge partnerships with one another.

The Specialist

Information from the field has provided us with valuable lessons on how consultants can facilitate their acceptance and inclusion in the program while avoiding a few common pitfalls that create barriers to successful relationships.

Program staff report that the relationship with specialists is smoother and more successful if the consultant demonstrates genuine interest in and respect for the program, its children, and staff.

Respect for the preschool program, as well as for the experience and expertise of its staff, is key to establishing a genuine partnership. If consultants treat their relationship with the program with the same respect and professionalism they bring to other settings (e.g., a hospital or private clinic), the relationship will begin and continue on a positive note.

As a specialist, you can create a climate of respect by paying attention to the following:

- *Know your client.* Do you have a genuine interest in the philosophy that guides the program and how the program and the classroom work? Do you ask questions? Do you spend time in the classroom observing or chatting with staff when you and they *both* have the time? If you take time to know the environment, staff concerns about your not understanding the program will be alleviated. Your services will be enhanced as well.

- *Realize and acknowledge that preschool program staff are experts too.* Do you demonstrate respect for the expertise, feelings, and priorities of the staff? Do you ask questions about what they observe and think, or about what is important to them when you are in their classrooms?

- *Communicate clearly and regularly.* Do you provide information in the way staff have requested it, avoid jargon, and solicit their feedback on a regular basis?

- *Maintain professionalism.* Do you take your appointments seriously, keeping cancellations at a minimum and communicating any scheduling changes as soon as you are able? Are your reports submitted on time?

- *Be a team player.* Do you feel and act like a member of a team, rather than the "expert?" Do you solicit information from the other "experts" in the program?

In addition to these issues, more practical information can help establish a partnership as well. For example, as the specialist, you would be wise to explain, early on and briefly, what you will be doing and why, what you would like from the classroom teacher, and any constraints (such as a very heavy caseload) you must deal with. Such disclosure can help staff understand you and your work a little better, and gives them a context in which to more fully understand the relationship.

Vignettes appear at the end of this chapter to demonstrate how seemingly minor interchanges or behaviors can be perceived by staff as a lack of interest or respect. By building a foundation of respect and interest from the start, you increase the probability that the same words and actions will be felt and interpreted in another, more positive way.

The Administrator

As the administrator, you provide the leadership that enables a successful partnership to emerge. As the person with the "big picture," you have an understanding of the child and his or her family, the constraints and needs of the classroom teacher, the expertise of the specialist, and the operation of the program. In a way, you are the most important person in ensuring a successful partnership, in that you establish program priorities, provide necessary resources to both staff and consultants, model behaviors, and resolve conflicts.

Working with Staff

Taking a few steps with the staff in the beginning of any program–specialist partnership will go a long way in ensuring a smooth working relationship. Initially, you'll want to make sure that staff members know why the specialist is joining the program and why it is important. Ideally, some of the staff will have been involved in establishing hiring criteria or interviewing potential consultants. Employees also need to know clearly what you will contribute to the effort, what you expect from them, and what they will get out of it.

For example, let's say your program will be enrolling Timmy, a four-year-old with cerebral palsy, in September. You have

already contracted with an agency to provide a physical therapist twice a week and you have met the specialist who will be coming on board. Ideally, before the fall session begins, you will conduct an inservice session where you orient staff to the situation, solicit any questions and concerns they may have, and enlist their support in the endeavor. By doing this, you lay the groundwork for a true partnership with a specialist, designed primarily to benefit the child, but also contributing to the adults. Suggestions for what you might include in the session appear below.

- Describe the need and the hiring process.

- Share your commitment and enthusiasm for the undertaking, and state what resources you will allocate to the effort.

- State clearly what you expect from staff in terms of how to orient the specialist to the classroom environment (e.g., share class rules ahead of time), help the specialist feel accepted in the classroom (e.g., greet the specialist when he or she enters), and communicate with you and the specialist (i.e., when and how to give feedback).

- Help staff understand that they will bring their own expertise to the partnership and that they will learn from the specialist about in-class interventions they can use to integrate children more fully.

- Encourage staff to voice their questions and suggestions, and address any issues of concern.

If possible, it is very helpful to have the entire staff meet the specialist before he or she starts work in the classroom. This will provide an opportunity for all to ask questions, share important information, and become acquainted ahead of time. Such a meeting helps everyone feel more in tune and comfortable and helps the specialist feel less like a stranger to the program staff and children.

While this type of orientation can be of enormous help in establishing a partnership, your words and actions once the relationship starts are key to its success. If you model

acceptance of and respect for the specialist and the program staff, remain available and open to feedback, and provide help with the inevitable difficulties that will occur, you will set the tone for a positive process.

Working with the Consultant

The aforementioned tips for staff, if followed, will help the consultant feel less like an intruder in the classroom and more like a welcomed member of the team. Your two primary responsibilities once the contract is signed are to support the consultant's effort by monitoring the specialist and the staff, and to be available to the consultant for feedback and support, progress and process reports, and troubleshooting. By valuing the consultant and his or her expertise and modeling this for your staff, you will pave the way for a strong partnership.

Attending to more practical matters can help the relationship stay on a positive note as well, including

- handling paperwork, such as obtaining permission to treat forms, and keeping insurance information up to date
- reimbursing in a timely fashion
- notifying in advance of schedule changes or the child's absence
- arranging transportation

When Difficulties Arise

That difficulties (or challenges!) will arise is probably the only thing you can count on. Situations and needs change, people change, and even the most thorough and honest discussions and contracts cannot possibly cover what will occur once the service is rendered and the relationship develops.

A few general tips might help when the partnership reaches an obstacle:

- Assume that difficulties are a part of every working relationship.
- Get involved as soon as you perceive a problem. Neglecting small problems can cause bigger ones down the road. Very

often what seems to be a minor interchange or action that caused negative feelings is a symptom of a larger disrespect that is being felt. Both specialists and teachers can feel devalued and it's important to air such feelings as soon as they arise.

- Solicit information, value all input, and maintain the focus on what is best for the child. It's easier to resolve conflicts when you keep your sight on the ultimate goal.

- Review the contract. Was it reasonable? Have things changed? Does it need to be revised?

- Remember you are the boss. If the relationship is not working, or if the consultant is not a good match or is not performing, you need to take charge and rectify the situation.

- Jot down what you learn from each such situation. Over time you will learn what you are doing—perhaps unconsciously—that contributes to problems with the partnership and you can avoid those actions in the future.

Vignettes

Below are scenarios typical in a preschool program that uses specialists to help integrate children with disabilities. The vignettes can help you become more aware of the issues that are important to each part of the team and can be used as a learning tool with staff and consultants for strategizing "What could have been done to make this situation better for everyone?"

Whose Classroom Is This Anyway?

A speech therapist arrives in the classroom to work with Lennie, who has a severe speech and language delay. She generally works with him within the classroom setting. Today, however, she has decided to administer an evaluation, since she has some new concerns.

Lennie is listening to a story with a small group of children. The therapist goes over to Lennie, talks to him for a short while, takes his hand, and starts to leave the room. On the way out of the room, she stops to gather some books and toys. The

classroom teacher watches this and thinks, "Whose classroom is this anyway?"

Turf issues can easily arise when there is no well-defined plan for how consultants will operate in the classroom. Both the classroom teacher and the therapist must clearly communicate their own needs and expectations and be respectful of each person's role. Among the many issues to be addressed prior to the first therapy session are the scheduled time for therapy, how schedule changes will be communicated, and where the therapy will take place.

What Could Have Helped?

The therapist could have communicated to the teacher or administrator her change of plans ahead of time, and asked the teacher if she could take Lennie to another room.

The teacher and therapist could have agreed explicitly at the beginning of the relationship that any change in procedure must be discussed ahead of time.

The teacher could have taken a moment to speak with the therapist as the incident was happening, rather than assume disrespect on the part of the specialist.

This Teacher Must Not Care

Beth, a child with Down syndrome, is working with a physical therapist within the classroom. To increase the muscle tone in Beth's legs, the therapist is conducting a gross motor activity with a large ball. She gets the classroom teacher's attention and asks her to come over to observe how well Beth is doing and to give the teacher an idea of what activities are helpful to Beth. The teacher goes over to the therapist and tries to listen—she also must keep track of what is going on in the group of children she has engaged in an activity. In frustration the teacher wonders, "Doesn't she know that I have an activity in progress? I can't stop what I'm doing to discuss Beth right now." The therapist thinks, "The teacher must not care much about Beth's progress."

Most consultants' schedules cover time to work with children on a one-to-one basis or with small groups. Consultants are

often "under the gun" to produce billable hours. These billable hours are generally for direct client contact only. Private and third party payors usually do not reimburse for ongoing meeting time between the consultant and classroom staff.

Typically, little attention is paid to how the consultant will connect with the teachers in the class. This communication is crucial for several reasons. First, it enables the consultant to provide ideas to reinforce the goals of therapy and update teachers on the child's progress and/or resolve problems. Second, it gives the teachers an opportunity to provide feedback or recommendations, ask questions, or strategize solutions with the consultant. Creating time for this communication also reinforces the notion that the consultant is available to support the teacher and vice versa.

When time is not set aside for the teacher and therapist to meet, information must be exchanged on an informal basis, or worse, not exchanged at all. When a consultant attempts to embark on a substantive discussion during the time the teacher has responsibilities for other children in the class, the teacher can feel frustrated and resentful.

What Could Have Helped?

The teacher and therapist could have agreed ahead of time that no discussions regarding the child can take place during class time, except to briefly share how well Beth is doing.

The therapist could have asked the teacher to come over to see how well Beth is doing, and acknowledging demands on the teacher, ask to meet briefly at another time to offer ideas about what activities are best for the child.

The teacher could have taken a moment to acknowledge how well Beth is doing and then, telling Beth and the specialist that she is engaged in another activity, made arrangements to speak with the specialist at another time.

The teachers and the consultant could have met before the first in-class intervention and agreed on a mutually satisfactory way and time to share information.

The program administrator could have allocated needed resources to facilitate opportunities for the classroom teacher and the therapist to have meeting time to discuss the status of children receiving services. For example, the administrator might do the following:

- Budget training dollars to pay consultants for weekly or biweekly meetings with the teacher.
- Enlist coordinators or volunteer staff to fill in for teachers to free them up to meet with consultants.
- Hire a substitute to be in the classroom occasionally so that the teacher can meet with the consultant. This strategy would also provide an opportunity for the teacher and the consultant to observe the child together. The consultant has time then to point out specific behaviors and situations and make recommendations to the teacher during the observation. Likewise the teacher has time to give full attention to observing the child, as well as an opportunity to give feedback and input to the specialist and ask questions or raise concerns.

She Should Get Her Priorities Straight

Barbara eagerly awaited the arrival of the physical therapist who will be consulting to her classroom on strategies for integrating Timmy, a four-year-old with cerebral palsy. The physical therapist was scheduled to arrive shortly before lunch in order to evaluate Timmy's adaptive skills. She will be working with Timmy throughout the year to provide therapy in the classroom two times per week. The therapist arrived, stood near the table while she observed Timmy during lunch, and then told him that "as soon as you clean your plate, we will play some games together." The teacher informed the therapist that none of the children were required to "clean their plates" before they could leave the table, and the rules were that everyone sat down while they completed their meal together.

The classroom teacher felt that the therapist did not respect or care about the classroom rules and routine, and the therapist questioned the significance of Barbara's displeasure over what seemed to be a minor issue. Each was left feeling that the other's priorities were off base.

This vignette illustrates a common occurrence. Without a proper orientation to the program and the classroom, teachers might assume that a consultant knows or can quickly perceive the philosophy of the program and the rules and routines of the classroom. The consultant, however, is focused on completing Timmy's assessment. Consultants find themselves in many classrooms, each with their own set of expectations and rules, so it is not reasonable to expect that they will automatically know how they should conduct themselves.

What Could Have Helped?

The program administrator, classroom teacher, or specialist could have made sure the specialist had an opportunity to become familiar with the classroom rules and routines prior to providing services.

The teacher and specialist could have had an orientation meeting to discuss classroom procedures.

The contract could have stipulated that, before providing services, the specialist must observe or participate in the classroom for two hours and meet with the classroom teacher for one hour to discuss the classroom routine and raise issues and concerns.

The program staff could have developed a packet of information to be given to all consultants, which includes descriptions of program philosophy, operations, and classroom procedures.

Summary

Discussions, if conducted early on, can have a positive impact on the relationship and the work the specialist does. Early childhood professionals and consultants agree that many of the difficulties in the relationship arise when important topics are not discussed ahead of time but only when problems occur. On the following page is a checklist for teachers and consultants to use before the specialist begins to work with children in the classroom.

TEACHER/CONSULTANT CHECKLIST

ISSUES TO DISCUSS BEFORE THE CONSULTANT BEGINS WORKING IN A CLASSROOM

Typical schedule for the day

Rules and procedures of the classroom

- ❑ Sharing
- ❑ Eating/Cleaning up
- ❑ Choosing activities
- ❑ Putting toys away
- ❑ Responding to exclusion of other children
- ❑ Responding to the use of unacceptable language and behavior
- ❑ Using "please" and "thank you"
- ❑ Greeting visitors to the classroom

Communication with children

- ❑ Recognizing a job well done
- ❑ Intervening when a child is aggressive
- ❑ Intervening when a child says or does something unacceptable

Communication between specialist and teacher

- ❑ Best time to discuss progress/problems
- ❑ Circumstances when in-class discussion is acceptable
- ❑ How and when written progress reports will be delivered to the teacher
- ❑ Availability of the specialist for phone calls

Scheduling

- ❑ Handling child absences and rescheduling
- ❑ Handling specialist absences and rescheduling

APPENDICES

Appendix A

RESOURCE ACCESS PROJECTS (RAPs)

Region I
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
New England RAP
Education Development Center, Inc.
55 Chapel Street
Newton, MA 02160
(617) 969-7100

Region II
New York, New Jersey, Puerto Rico, Virgin Islands
New York University RAP
Department of Human Services and Education, SCE
48 Cooper Square, Room 103
New York, NY 10003
(212) 998-7205

Region III
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Child Development Resources
Post Office Box 299
Lightfoot, VA 23090
In Virginia, West Virginia, Maryland, and Delaware
(800) 237-7273 or (804) 565-1513
In Pennsylvania (800) 445-7273 or (202) 338-1698
In Washington, D.C. (202) 687-8635

Region IV
Florida, Georgia, North Carolina, South Carolina
Region IV RAP
Chapel Hill Training-Outreach Project
800 Eastowne Drive, Suite 105
Chapel Hill, NC 27514
(919) 490-5577

Mississippi, Tennessee, Alabama, Kentucky
Region IV RAP
141 Mayes Street
Jackson, MS 39213
(601) 362-9154

Region V
Illinois, Indiana, Ohio, Michigan, Minnesota, Wisconsin
Great Lakes RAP
Colonel Wolfe School
403 East Healey
Champaign, IL 61820
(217) 333-3876

RAPs (continued)

American Indian Grantees
Three Feathers Associates
Post Office Box 5508
Norman, OK 73070
(405) 360-2919

Migrant Program Grantees
InterAmerica
7926 Jones Branch Drive
Suite 1100
McLean, VA 22102
(703) 893-3514

RAPs (continued)

Region VI
Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Texas Tech University RAP
Post Office Box 4170
Lubbock, TX 79409
(800) 527-2802 or (806) 742-3296

Region VII
Iowa, Kansas, Missouri, Nebraska
Region VII RAP
CRU G 001
University of Kansas Medical Center
3901 Rainbow Boulevard
Kansas City, KS 66160-7339
(913) 588-5961

Region VIII
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
Region VIII RAP
University of Colorado at Denver
Campus Box 193
Post Office Box 173364
Denver, CO 80217-3364
(303) 893-0330

Region IX
Arizona, California, Nevada, Guam, Hawaii, American Samoa
Southwest Human Development
202 East Earll, Suite 140
Phoenix, AZ 85012
(602) 266-5976

Region X
Idaho, Oregon, Washington, Alaska
Region X RAP
School of Extended Studies
Portland State University
Post Office Box 1491
Portland, OR 97207
(800) 547-8887, ext. 4815, or (503) 725-4815

Appendix B

UNIVERSITY AFFILIATED PROGRAMS (UAPs)

University of Arkansas
Little Rock, AR
(501) 370-1487

Children's Hospital
Los Angeles, CA
(213) 669-2151

University of California
Los Angeles, CA
(213) 825-0147

University of Colorado
Denver, CO
(303) 270-7224

University of Connecticut
East Hartford, CT
(203) 282-7050

Georgetown University
Washington, DC
(202) 687-8635

University of Miami
Miami, FL
(305) 547-6635

University of Georgia
Athens, GA
(404) 542-3457

University of Hawaii
Honolulu, HI
(808) 948-5009

University of Idaho
Moscow, ID
(208) 885-6773

University of Illinois
Chicago, IL
(312) 413-1647

Indiana University
Bloomington, IN
(812) 855-6508

Indiana University
Indianapolis, IN
(317) 724-8167

University of Iowa
Iowa City, IA
(319) 252-6390

Kansas University Medical Center
Kansas City, KS
(913) 588-5900

Parsons UAP
Parsons, KS
(913) 864-4950

University of Kansas
Lawrence, KS
(913) 864-4295

University of Kentucky
Lexington, KY
(606) 257-1714

Louisiana State University
New Orleans, LA
(504) 942-8200

Johns Hopkins University
Baltimore, MD
(301) 550-9000

Children's Hospital
Boston, MA
(617) 735-6501

Shriver Center UAP
Waltham, MA
(617) 642-0001

Wayne State University
Detroit, MI
(313) 557-2654

University of Minnesota
Minneapolis, MN
(612) 624-4848

UAPs (continued)

Virginia Commonwealth University
Richmond, VA
(804) 225-3876

University of Washington
Seattle, WA
(206) 543-2832

West Virginia University
Morgantown, WV
(304) 293-4692

University of Wisconsin
Madison, WI
(608) 263-5940

UAPs (continued)

University of Southern Mississippi
Hattiesburg, MS
(601) 266-5163

University of Missouri
Kansas City, MO
(816) 276-1770

University of Montana
Missoula, MT
(406) 243-5467

University of Nebraska
Omaha, NE
(402) 559-6430

University of New Hampshire
Durham, NH
(603) 862-4320

University of Medicine and Dentistry of New Jersey
Piscataway, NJ
(201) 463-4447

University of Rochester
Rochester, NY
(716) 275-2986 or 275-4836

Westchester County Medical Center
Valhalla, NY
(914) 285-8204

Yeshiva University
Bronx, NY
(718) 430-2325

University of North Carolina
Chapel Hill, NC
(919) 966-5171

Ohio State University
Columbus, OH
(614) 292-8365

University Affiliated Cincinnati Center
Cincinnati, OH
(513) 589-4623

Oregon Health Sciences University
Portland, OR
(503) 279-8364

University of Oregon
Eugene, OR
(503) 686-3591

Temple University
Philadelphia, PA
(215) 787-1356

University of South Carolina
Columbia, SC
(803) 777-4839

Winthrop College
Rock Hill, SC
(803) 323-2244

University of South Dakota
Vermillion, SD
(605) 677-5311

University of Tennessee
Memphis, TN
(901) 528-6511

University of Texas
Austin, TX
(512) 471-4161

Utah State University
Logan, UT
(801) 750-1981

University of Vermont
Burlington, VT
(802) 656-4031